

Perception of oncological patients about verbal and non-verbal communication when receiving bad news

Percepção dos pacientes oncológicos sobre a comunicação verbal e não verbal no recebimento de más notícias

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Cruvinel AFP, Thomas B, Klaus GB, Silva TG. Perception of oncological patients about verbal and non-verbal communication when receiving bad news / *Percepção dos pacientes oncológicos sobre a comunicação verbal e não verbal no recebimento de más notícias*. Rev Med (São Paulo). 2021 Nov-Dec;100(6):561-9.

ABSTRACT: Bad news is any sort of communication of an informative nature that negatively affects an individual's prospects. When related to oncology, it can permeate different stages of the disease from the diagnosis itself. So, this study aims to evaluate the perception of cancer patients about verbal and non-verbal communication when receiving bad news in a hospital in western Santa Catarina. That said, the research methods are based on qualitative data, carried out between December 2019 and January 2020, with 15 patients between 18 and 60 years old, admitted to the oncology or chemotherapy clinic of a hospital in western Santa Catarina. The selection of participants was done by convenience, with the quantity determined by theoretical data saturation. Information was collected through a narrative interview, which was transcribed and analyzed using the IRAMUTEQ® program. The program resulted in four classes named according to the most representative words, and thus, the patients' preference in using clear and understandable language was evidenced, without omitting clinical data, taking into account the singularities of each individual. In addition, the importance of faith and spirituality at the time of communication is perceived, with the person-centered approach being key to the process.

Keywords: Health communication; Oncology; Patient preference; Nonverbal communication; Truth disclosure; Physician-patient relations.

RESUMO: A má notícia consiste em toda comunicação de caráter informativo que afeta negativamente as perspectivas futuras de um indivíduo. Quando relacionada à oncologia, pode permear diferentes fases da doença a partir do próprio diagnóstico. Então, este trabalho tem como objetivo avaliar a percepção dos pacientes oncológicos sobre a comunicação verbal e não verbal no recebimento de más notícias em um hospital do oeste catarinense. Posto isto, os métodos da pesquisa baseiam-se em dados qualitativos, realizados entre dezembro de 2019 até janeiro de 2020, com 15 pacientes entre 18 e 60 anos, internados na clínica oncológica ou de quimioterapia de um hospital do oeste catarinense. A seleção dos participantes foi feita por conveniência, com o quantitativo determinado pela saturação teórica dos dados. A coleta de informações foi realizada por meio de uma entrevista narrativa, que foi transcrita e analisada pelo programa IRAMUTEQ®. O programa resultou em quatro classes nomeadas conforme as palavras de maior representatividade, e assim, foi evidenciada a preferência dos pacientes na utilização de uma linguagem clara e compreensível, sem omitir dados clínicos, levando em conta as singularidades de cada indivíduo. Além disso, percebe-se a importância da fé e espiritualidade no momento da comunicação, sendo chave do processo a abordagem centrada na pessoa.

Palavras-chave: Comunicação em saúde; Oncologia; Preferência do paciente; Comunicação não verbal; Revelação da verdade; Relação médico-paciente.

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INTRODUCTION

Bad news is defined as any informative communication that negatively affects an individual's future prospects¹. In the clinical context, it is mainly linked to the area of oncology, related to diagnosis, recurrence, or transition from curative treatment to palliative care². Adequate communication, through its verbal and non-verbal components, is essential in delivering bad news, being essential to improve the doctor-patient relationship³. The verbal component refers to the content of the message, mainly to the fact of word choice. The non-verbal component includes elements such as posture, gestures, facial expression, and interpersonal distance, while the paraverbal component consists of the tone, rhythm, and volume of the voice. Although the majority of the population considers the verbal component as the most important, non-verbal and paraverbal components contribute 90% of the total message⁴.

Several strategies are adopted by physicians when communicating bad news, however, there are significant differences in the way it occurs⁵. It is known that good communication reduces the patient's mental suffering, improves the understanding of their disease and improves treatment adherence⁶. As tools for medical professionals in communicating bad news, different protocols were developed, including SPIKES, developed by Robert Buckman in 1992¹. This protocol provides a detailed guide on how to communicate bad news. Each letter represents the steps that the professional must follow, respectively: Setting up, Perception, Invitation, Knowledge, Emotions and Strategy and Summary⁷. In the item Setting up (planning the interview) the appropriate place for dialogue is recommended, preferably in the presence of a companion. Next, Perception (evaluating the patient's perception) concerns the physician's understanding of the family's and the patient's knowledge of the medical situation. In the Invitation stage (obtaining the patient's invitation), the patient and their families are asked about the type of information that will be of interest to them, culminating in the Knowledge phase (giving information to the patient), in which the news is shared, in a leisurely and objective way. Finally, Emotions (addressing the patient's emotions) discusses the physician's empathic attitude towards the situation, respecting the patient's moment of understanding, ending with a Strategy and Summary (strategy and summary) a general summary of the clinical condition and treatment perspectives⁸.

The way in which bad news is delivered to patients directly impacts their emotions and attitudes towards their health condition, in addition to perspectives regarding their treatment and adherence to clinical recommendations⁹. A study carried out with 350 cancer patients revealed that only 46% were satisfied with the way the bad news was communicated, with the clear diagnosis and progress of the

disease being emphasized by them as the most important points, highlighting the lack of skill of physicians in realization of this competence¹⁰.

Thus, it is essential for the medical team to understand the preferences of patients when sad news is received¹¹. Thus, given the above, this study was consolidated through the perception of cancer patients in relation to verbal and non-verbal communication during the delivery of bad news by the doctor in a hospital in western Santa Catarina. Thus, it is intended to contribute to a better understanding of the patient's preferences regarding the physician's communicative skills, which will enable the development and strengthening of the communication of health professionals regarding the wishes of their patients.

OBJECTIVE

This study aims to evaluate the perception of cancer patients about verbal and non-verbal communication when receiving bad news in a hospital in western Santa Catarina.

METHODOLOGY

The study is a research with a qualitative approach, carried out in a hospital in western Santa Catarina with 15 patients undergoing cancer treatment hospitalized in the inpatient or chemotherapy sector. The project was approved by the Ethics Committee (CAAE 20233719.2.0000.5564) and followed Resolution 466/2012. The number of participants was determined through the technique of theoretical data saturation, when the results obtained to start to present, in the researcher's assessment, a certain redundancy or repetition¹².

Based on convenience sampling and theoretical saturation, patients aged between 18 and 60 years undergoing cancer treatment and who agreed to participate in the research were considered eligible. Patients who did not speak Portuguese or who were not in a clinical condition to respond were excluded. Data were collected from December 2019 to January 2020, through narrative interviews followed by complementing the answers, with an instrument consisting of 10 semi-structured questions elaborated by the researchers based on the SPIKES protocol.

Before starting the collection, the performance status and age of the patients were evaluated with the nursing team, so that those who fit the criteria previously determined by the study could be selected. To those eligible, the research objectives and methods used were explained, as well as the possible risks related to discomfort and fatigue. Those who expressed interest were asked to read and sign the Informed Consent Form (TCLE).

Patients who agreed to participate in the research were invited to go to a reserved room on the floor where they were admitted, and those who experienced difficulty

in walking were helped with a wheelchair. The researchers tried to establish a calm relationship, motivating free speech. Before starting the interview, all of the participants gave their information concerning age and gender. Next, the researchers explained how the dialogue would be conducted. Initially, individuals were encouraged to tell about the moment they received the news about their medical situation, through the following guiding question: “Tell me about the moment you received the diagnosis of cancer”. Next, they were asked about aspects related to verbal and non-verbal communication during the process, according to the script.

During the narration, the researchers did not interrupt the participants, assent with non-verbal signs of attentive listening and encouragement for the continuity of the discourse, such as: “Tell me more about this” or “You can be comfortable”. When the patient signaled the end of the story, he was asked if there was anything else he would like to talk about. And then, when the narrative ended spontaneously, the questioning phase began with the use of the informant’s language to fill in the gaps in the story. The question about the subject occurred differently with each participant, and their questions were elaborated in the narrative process according to the need of the researchers to obtain the outcome of the situation, based on a script previously elaborated with exmanent and immanent questions.

The interviews were recorded in a digital system and transcribed in full for further analysis, and at the end of each one, the researchers thanked them for their participation and the time dedicated to the interview. To continue the study, data analysis was performed using free software, called IRAMUTEQ® (R interface pour les Analyses Multidimensionnelles de Textes et de Questionnaires)¹³. Initially, the transcribed content of all interviews was unified into a single corpus for insertion in IRAMUTEQ®. As an analysis technique, Classical Lexicographic Analysis, Factorial Correspondence Analysis (CFA), and Descending Hierarchical Classification (CHD) were performed using the same software.

CHD relates the position of a word along with the text and its periodicity, generating a calculation of its frequency. Through this calculation, the IRAMUTEQ® provides the chi-square (χ^2), which consists of a statistical frequency indicator, which signals its highest value and its greatest representation in the speeches of the interviewed subjects, thus creating a hierarchical class structure. So, these classes are characterized by a set of words originating from the same textual meaning, which through χ^2 evidences the strength of association between the words and their representative class¹⁴.

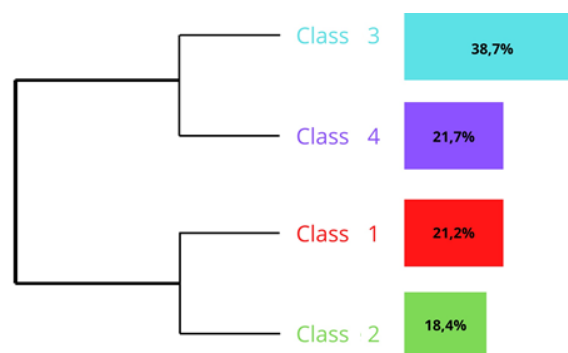
The data from this study were organized through the investigation of the corpus of interviews, based on the CHD performed by the IRAMUTEQ® program. Initially, research participants and their characteristics

will be presented for a better understanding of the subjects involved.

RESULTS

Fifteen patients undergoing cancer treatment admitted to a hospital in western Santa Catarina participated in the research, 10 females and five males, with a mean age of 49.73 (± 9.90) years. In addition, the corpus consisted of 15 texts separated into 307 Text Segments (ST) with the use of 217 ST and retention of 70.68% of the material submitted for analysis. The software recommends at least 70% use of the corpus to be considered representative. The present study, in this way, reaches the expected representativeness criterion, 10837 occurrences (words, forms or words) emerged, with 1420 distinct words and 663 with a single occurrence.

The main analysis technique of IRAMUTEQ®, CHD, generated four classes (clusters): class 1 with 46 ST (21.2%), class 2 with 40 ST (18.43%), class 3 with 84 ST (38.71%) and class 4 with 47 ST (21.66%). This distribution of classes can be seen in the first dendrogram (Figure 1) generated by the software with demonstrations of the relationships between them.



Source: IRAMUTEQ software, survey data, 2020.

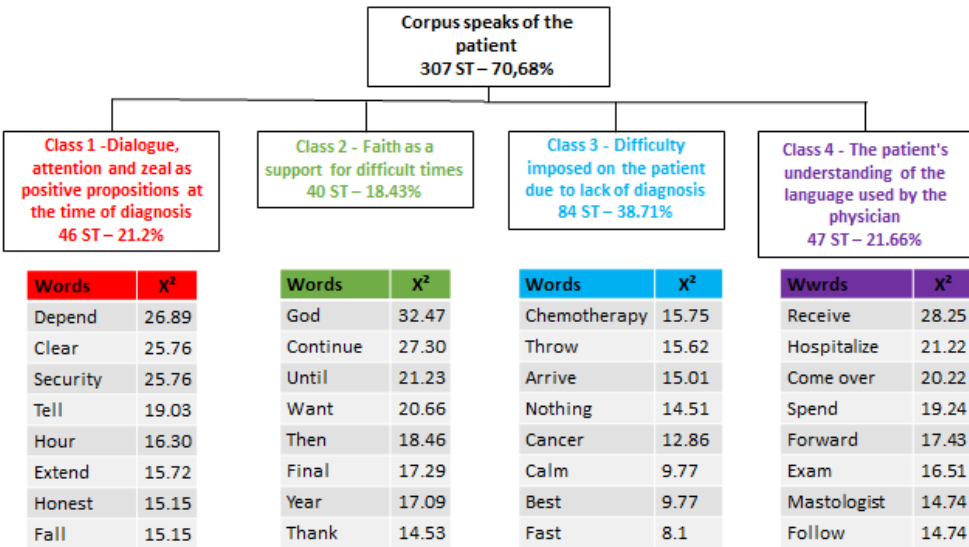
Figure 1 - Descending Hierarchical Classification Dendrogram

The classes are divided into two branches of the corpus (subcorpus A and subcorpus B). Subcorpus A is composed of class 1 called “Dialogue, attention and sincerity as positive propositions at the time of diagnosis”, and class 2 “Faith as support for difficult times”. Subcorpus B is formed by class 3 and class 4, referred to respectively as: “Difficulties imposed on the patient due to lack of knowledge about the diagnosis” and “The understanding of the patient regarding the language used by the physician”.

The CHD dendrogram (Figure 1) allows understanding the words spoken by the participants, analyzing them from their places and social insertions¹⁵. The reading should be done from top to bottom, in this case,

classes 1 and 2 have a greater correlation with each other and, likewise, classes 3 and 4. To facilitate the visualization of the classes, Figure 2 shows an organizational chart

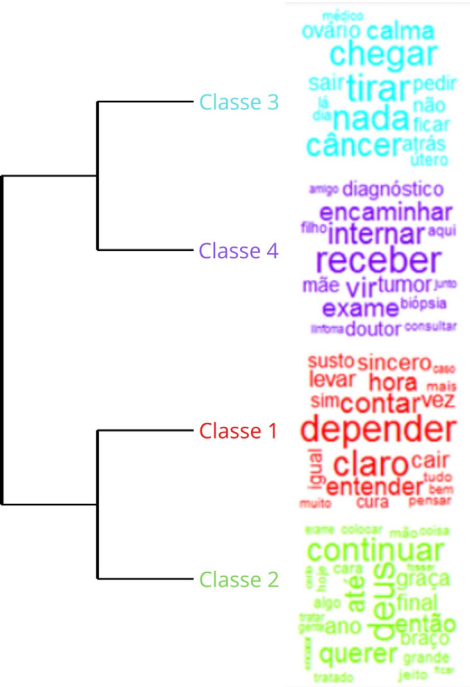
with the list of words of each generated class and their associative strength, calculated through Pearson's chi-square test and generated by IRAMUTEQ®.



Source: IRAMUTEQ software, survey data, 2020.
Figure 2 - Organizational chart of classes with their respective words and associative forces

Figure 3 presents the classes with their specific word cloud in order to facilitate the visualization and understanding of the data.

In Figure 4, the word cloud represents the entire corpus used for the analysis, showing the words graphically as a function of their frequency.



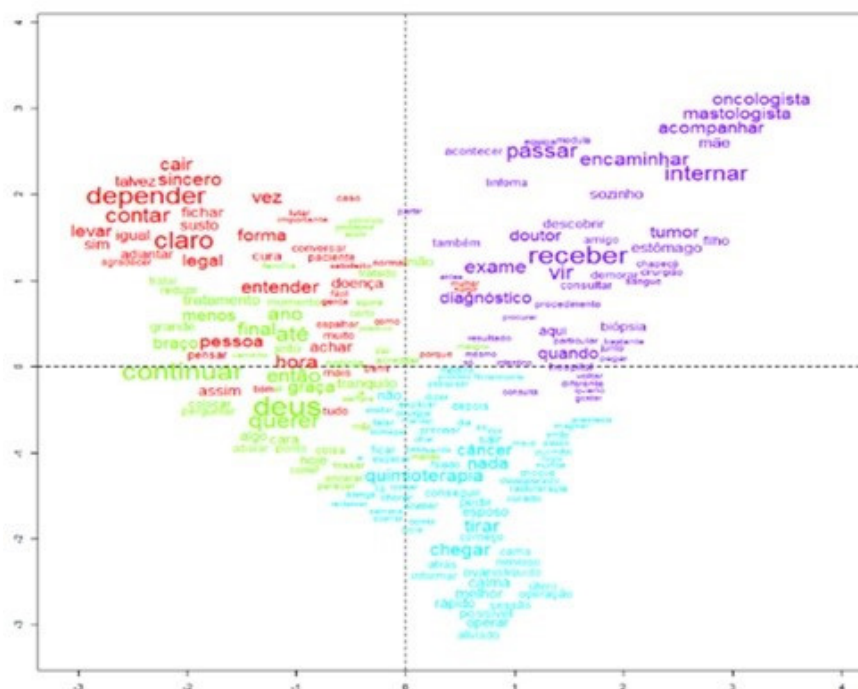
Source: IRAMUTEQ software, survey data, 2020.
Figure 3 - Emerging word cloud distributed by classes



Source: IRAMUTEQ software, survey data, 2020.
Figure 4 - Word cloud from the textual corpus

The Factorial Correspondence Analysis (CFA) enables the association between words, evaluating the frequency of each one in the classes (Figure 5).

Words from classes 1 and 2 are strongly correlated, representing greater proximity in the image. Classes are more distributed in the quadrant with the smallest approximation between them.



Source: IRAMUTEQ software, survey data, 2020.

Figure 5 - Correspondence Factor Analysis (CFA)

DISCUSSION

This study aimed to evaluate the perception of cancer patients in relation to verbal and non-verbal communication during the delivery of bad news by the doctor in a hospital in western Santa Catarina. The findings are important to the medical practice, as the ability to communicate bad news has a direct impact on the individual's quality of life, as often the patient's emotional condition, as well as the complexity of the information, can lead to difficulties in understanding the news, resulting in dissatisfaction and even a denial of the fact¹⁶.

For a better understanding of the results achieved during the narratives, 4 classes were classified, according to the analysis of the IRAMUTEQ® software. According to the CHD, shown in Figure 1, the class with the greatest representation in the corpus was class 3, which showed dissatisfaction when the physician did not clarify the patient's health status, delaying the diagnosis information for the next appointment or even redirecting this assignment to someone else.

Figure 2 reveals the words with greater associative strength in class 3: "chemotherapy", "take away", "arrive", "nothing" and "cancer", demonstrating the relationship between the patient's preferences and negative points at the time of diagnosis. The relationship between the words that make up class 3 and the degree of dissatisfaction of patients during the delivery of the diagnosis can be seen, cited by:

E2 "[...] but he didn't explain to me that it was cancer, he said it was just to remove the ovary" and

E15 "[...] later he sent another doctor to discharge me, but he also didn't explain anything, so I wanted him to come and say why I would leave the hospital more relieved".

Freiberger and Bonamigo¹⁷ also point out failures in communication, with incomplete or inadequate information and a lack of medical empathy, which could be improved through the development of communication skills. Authors describe that several factors can justify the lack of training during the training of medical professionals related to clear communication skills, as well as working conditions, such as the excessive number of appointments, high workload and mental and physical fatigue¹⁷.

The patient's dissatisfaction regarding the receipt of their diagnosis can be explained by the physician's lack of perception of the singularities of each individual, as several emotional, cultural and social factors interfere in the moment of understanding a piece of news¹⁸. This can be explained by culturally stigmatized words, such as "cancer" and "drug therapy", related to the perception of a feeling of death, suffering and pain, leading to a denial of the fact and, consequently, misunderstanding of the diagnosis and lack of adherence to treatment¹⁹.

Thus, the communication of bad news requires sensitivity and compassion from the physician, and should not be seen only as a merely informative dialogue,

but also prospectively, seeking to understand the feelings and emotions of each patient, in order to establish good communication and creation of a bond of trust^{20,21}.

The second class with the highest representation (21.7%) of the corpus was class 4 (Figure 1), referring to the patient's understanding of the language used by the physician. In general, patients had good comprehension of their diagnosis, therefore, the language used was considered adequate, as in:

E15 "[...] but in terms of when I found out my diagnosis it was very calm, the doctor explained to me well what I would have to do all the processes I was going to go through" and

E13 "[...] when I came back with the exams in hand, the doctor here talked to me a lot".

Properly performed verbal communication is one of the main points related to patient satisfaction with the delivery of bad news and a better understanding of the diagnosis. This finding is in line with the study by Mirza et al.²², in which it was found that most cancer patients were satisfied with receiving the communication. The most relevant points highlighted by them when receiving bad news were: empathy and concern of the physician concerning their health status, communication in a clear, organized and paused manner and, finally, that this includes the entire diagnosis, treatment and prognosis, making sure the patient has understood all the steps.

Still, it is clear that some individuals report that physicians could improve this communication, as in

E10: "[...] he should have explained, but he didn't explain anything to me, the way he said it was weird" and

E9: "[...] I would like to know and I saw what it was (the treatment) looking at the papers he gave me, but he did not tell me what type I would receive, I would have liked to have received this guidance".

Similar to the present study, Bastos et al.²⁰ and Taylor et al.²³ also reported the patient's preferences at the time of diagnosis through clear communication, avoiding using technical terms about their disease, but at the same time maintaining discourse of hope and positivity regarding treatment and prognosis²⁴.

It is essential to understand the diagnosis when receiving bad news, as it influences the patient's view of the health-disease process and how the treatment will be followed. The behavior of physicians and the way they deliver bad news are key elements that strongly influence the future therapy of those involved. This impacts the patient's decision to continue or discontinue treatment and also leads him to choose to continue under the guidance of the same specialist or seek another one²¹.

In this sense, class 1 refers to dialogue, attention and sincerity as positive propositions at the time of diagnosis.

It is noticed that patients, when informed about their situation, value the honesty and attention of the physician, as evidenced by

E1: "[...] gratitude to him because he was very sincere, all doctors should be the same as my doctor when giving the diagnosis to patients, he was very clear and with simple words that we understand" and

E4: "[...] she talked to me and my family, she was very calm, explained how it would be, explained that she has a cure, how it works, how many treatments more or less".

Similar to the present study, Freiburger and Bonamigo¹⁷ also infer that the physician's attitude towards the diagnosis, when performed with empathy, education and dialogue, are qualities valued by the individual during the delivery of bad news, which can provide a reduction in suffering during this time course. Nevertheless, a fundamental part of this process is the physician's honesty during communication, evidenced by the words of greater associative strength in this class, according to Figure 2: "depend", "of course", "security", "count" and "sincere", among others. These words show the patients' preference for the physician to be frank and truthful when delivering their diagnosis.

Brown et al.²⁵ also report in their study that one of the fundamental points listed in the preferences of those involved is that the physician should act honestly and include the patient in decision-making, explaining its possible consequences. For Hillen, Haes and Smets²⁶, the establishment of a trusting doctor-patient relationship improves the understanding of bad news, as well as a reduction in the feelings of fear and anxiety, common in this period.

The person-centered approach is also a fundamental part of this process, seen through the word cloud of the textual corpus (Figure 4), the most cited terms during the reports were: "patient", "why" and "people". It is inferred that, when patients receive their diagnosis, they want it to be carried out taking into account the individual's singularities. The person-centered approach method highlights the importance of integrating each person's perspectives, including their fears, concerns and experience of their illness with the physician's understanding of the case. In this sense, the professional must understand the individual as a whole, as well as the context in which they are inserted and their expectations and decisions, being a key point in their prognosis and treatment²⁷.

It is known that non-verbal language is also a fundamental part of the process of delivering bad news, generating benefits in the relationship of trust between doctor and patient, mainly through eye contact, body posture and smile²⁸. However, in the present study, it is noted that patients barely addressed it in their narratives, especially when it came to the physician's body language, even with the researchers questioning later about this

form of communication. The few reports of patients on the subject address the importance of non-verbal language through a careful look, gestures of empathy and concern, as in:

E9: “[...] yes, I was satisfied with the way the doctor gave me the diagnosis, he even gave me a hug when I started to cry and told me not to be sad”.

This evidenced fact can be explained by the researchers’ questions during the interviews that take place months after the diagnosis of their disease, and when patients invoke the word “cancer”, they refer mainly to the moment when the doctor said it during their diagnosis, marking in their memories the words spoken by the professional. When receiving bad news, non-verbal communication influences the patient’s perception of how the diagnosis was delivered, but it is clear that months or years after the diagnosis, patients only evoke verbal communication. It is inferred, therefore, that the non-verbal form of communication is not essential at this time, however, for the patients in the present study, they were not highlighted during the interviews.

It is essential when dealing with bad news, the adoption of an empathetic and honest attitude by the physician, which allows the patient to understand the real situation of their disease and actively participate in the decisions regarding their treatment. In addition, class 2 reverberates the importance of faith, in believing in something as support for times of difficulty, cited by:

E13: “Easy, I’m facing with faith in God and whatever God wants I’ll have to face there’s no other way if I surrender it’s not possible [...]” and

E12: “[...] you have to have a lot of strength and a lot of support, if you don’t have it you can’t fight and I thank God at this point I always received a lot of strength, I can’t complain and I still give strength to my girls today”.

According to figure 1, it can be seen that it is the class with the lowest representation in the corpus (18.43%). This fact may be due to the increased representation of other classes and not to a lack of spirituality on the part of patients, as the study by Nazi et al.²⁹ revealed that most patients used their religious and/or spiritual beliefs in coping of the disease and mentioned that professionals should take this fact into account when providing care.

After receiving bad news, feelings of hopelessness, fear and suffering are very common³⁰. It is observed in Figure 2, the words with greater associative force in this class: “God”, “continue”, “until”, “want”, among others, showing the relevance of the spiritual side that the individual has, especially during moments of difficulty. Guerreiro et al.³¹ state that spirituality is considered a powerful support tool in coping with the challenges imposed after receiving a cancer diagnosis, as it contributes to alleviating suffering, improving expectations during treatment, and in the resignification of the disease to the person. A study by Pinto

et al.³² corroborates this fact, emphasizing that most cancer patients with spiritual support reported improvement in treatment adherence and understanding of their diagnosis.

In Figure 5, which concerns the Factorial Analysis by Correspondence (CFA), it is evident that class 2 enters the others, with an association with classes 1 and 3 being represented in the figure, demonstrating the relationship of faith and spirituality during understanding and understanding of the diagnosis. In this sense, it is noted that the establishment of a support network is essential during this period, such as family support as a source of healing and spirituality as a means of achieving peace and a multidisciplinary team trained to deal with these situations³³.

The study found limitations determined by its execution in only two scenarios (inpatient and chemotherapy sector) of a single hospital institution. In addition, there is a lack of some data at the time of the interview, such as education level and type of cancer stage, which could elucidate trends in the perspective of patients with the communication of bad news depending on these conditions. Also, it presents the bias of the person already hospitalized receiving treatment, when needing to remember the moment when the diagnosis of cancer was communicated to him.

CONCLUSION

Knowing the perception of cancer patients about verbal and non-verbal communication at the time of delivery of bad news by the physician is essential for the successful transmission of the diagnosis, interfering with the understanding of the disease and the patients’ attitude towards treatment and prognosis. The present study demonstrates that when receiving the news about the situation of their disease, patients want their singularities to be taken into account, using clear and understandable language, without omitting information about their clinical condition.

Faith and spirituality were also cited as tools for coping with this period. Non-verbal language was little evidenced by the patients, but it still plays an essential role at the time of diagnosis. Given the reported preferences, it is essential to institute continuing medical education programs in the curriculum of undergraduate medicine and medical residency, in order not only to improve communication skills but also to personalize the way it is said, leaving aside the systematic form provided today, giving little value to the social, emotional and cultural aspects of both the patient and the assistant physician.

In short, the important positive relationship between the person-centered approach and the patients’ degree of satisfaction when receiving bad news can be seen. Therefore, it is concluded as an essential part for the physician to take into account the individual’s wishes when they are informed about the situation of their disease.

Authors' participation: *Agnes de Fátima Pereira Cruvinel*: guidance and final review. *Brenda Thomas*: bibliographic review, data interpretation and manuscript writing. *Georgia Baldo Klaus*: article development. *Tatiana Gaffuri da Silva*: data analysis, data interpretation and final review.

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Submitted: 2021, March 18

Accepted: 2021, July 12